EXHIBIT “E-2”

Continuation of Medical Records
Attached to Meier Affidavit

EMPLOYEES' RETIREMENT SYSTEM OF GEORGIA

SSN #: 260 / 94 / 5083

EMPLOYEE'S REQUEST FOR DISABILITY INFORMATION FROM PHYSICIAN/PHYSICIAN'S REPORT
(ERS, PSERS & GJRS ONLY)
(Return to ERSGA within 10 Business Days)

Please read all instructions on the opposite facing page carefully before filling out this form.

SECTION 1 – EMPLOYEE GENERAL INFORMATION – To be completed by employee

Name: MR. WILSON DAVID R DOB 01 19 1957
(Suffix, Last, First, and Middle Initial)

Position Title: SENIOR TROOPER

NOTE: Attach a copy of your complete employer job description which details job responsibilities, including critical job duties.

SECTION 2 – PHYSICIAN INFORMATION – To be completed by employee

Physician's Name *(Last, First and Middle Initial, if applicable)* and Specialty:
MEIER, EDWARD E. AND JACKSON, MICHAEL S

Mailing Address: 2304 SHORTER AVE ROME GA 30161
Number, Street, and Apartment # | City | State | Zip Code | Country (if not USA)

Daytime Phone: (706) 233-4000 Fax Number: (706) 233-4006

E-mail Address *(if applicable)*:

SECTION 3 – EMPLOYEE AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

"This is my written authorization to release to the Employees' Retirement System of Georgia (ERSGA) any and all medical records and information for the purpose of processing my disability retirement application. This includes any psychiatric/psychological records."

Signature: David R Wilson Date: 08/12/2005
(MM/DD/YYYY)

WMR 00038

EMPLOYEES' RETIREMENT SYSTEM OF GEORGIA

SSN #: 260 / 94 / 5083

SECTION 4 – EMPLOYEE DISABILITY INFORMATION – To be completed by Physician

IMPORTANT: Please read all instructions on page 4 carefully before answering the questions below.

What is/are the diagnosis/diagnoses for the cause of the disability?
acute compression fracture
thoracic spine T 12 to T 10

When was the onset of the disability?
09-07-2004

What are the specific physical findings and test results confirming this diagnosis? Please attach copies of these test results. If cancer is involved, attach copies of the confirming pathology reports. If AIDS is involved, attach copies of HIV and CD4 test reports. If you do not have copies of these reports, please tell us where they can be obtained. see attached MRI report.

What are the specific conditions disabling this patient?
severe back pain; compression fracture

What treatment have you recommended? Has the patient followed through with the recommended treatment? Please give dates *(MM/DD/YYYY)* and the results of treatment.
Pt. seen here & treated conservatively from 9-8-04 through 11-16-04 - and care transferred to specialist.

Are any treatments, tests, or surgery pending or anticipated? Please list.
deferred to specialist

Have you referred this patient to any other physician(s)? If so, please give the name, specialty, address and date of referral. Yes - DR. Scott Bowerman
Orthopedics
1013 North 5th Avenue, St. 7
Rome, Ga. 30165

WMR 00039

EMPLOYEES' RETIREMENT SYSTEM OF GEORGIA

SSN #: 260 / 94 / 5083

SECTION 4 – EMPLOYEE DISABILITY INFORMATION –To be completed by Physician - *continued*

Please give any other information that you think will assist in the determination of this person's case. If more space is needed, please attach additional pages.

For the currently held position and according to the attached employer job description, I find that this patient is (*please check one*):

___ Able to perform the job as described.

___ Unable to perform the job as described *at this time,* but may be able to recover sufficiently to return to work by _____.
(MM/DD/YYYY)

✓ Unable to perform the job as described and I am recommending disability retirement. Please enter the specific job duties that the patient cannot perform:
after reviewing Dr Bowerman's note, and assessment, also psych assessment, I feel pt. cannot perform his job and recommend disability retirement.

Section 5 – PHYSICIAN / HOSPITAL / CLINIC CERTIFICATION

"I certify that the above information is true."

Physician/Hospital/Clinic's Authorized Signature: [signature]

Title: MD Date: 8/23/05
(MM/DD/YYYY)

Phone Number: (706) 233-4000 Fax Number: (706) 233-4006

WMR 00040

RICHARD D. HARK, Ph.D., P.C.
P. O. BOX 5986
ROME, GEORGIA 30162-5986
LICENSED PSYCHOLOGIST 706/291-0631

April 29, 2005

Mr. Miles Gammage
Attorney At Law
P. O. Box 930
Cedartown, GA 30125

RE: David R. Wilson
SSN: 260-94-5083
DATE SEEN: 4/29/05

Dear Mr. Gammage:

I appreciate your referring Mr. Wilson for a psychological IME and providing copies of copious medical records including the clinical notes of Dr. Bowerman. Mr. Wilson is a 48-year-old male who completed the 12th grade and has worked as a Georgia State patrolman from 1990 until his taser-related accident on September 7, 2004. Since that time, he has been employed on a light duty job as a dispatcher.

Current Status. As you know, Mr. Wilson was subjected to a taser gun exposure as required by the GSP and, as a result, he suffered a compression fracture at T-6 and T-8. Currently, he takes no Rx medications to treat pain and does not wear a brace or use a TNS unit or assistive devices. However, he reports experiencing localized and often lancinating pain or burning and soreness in the thoracic portion of his spine. The pain is periodic and often caused by performing nonstressful activities such as placing a pitcher of iced tea in the refrigerator or reaching in front of him while cooking, etc. Mr. Wilson describes this pain as often almost heart stopping in intensity.

Because of his chronic and periodic pain, Mr. Wilson feels that he would not be able to participate in a required defensive tactics course, yearly qualify at the firing range (e.g., firing a shot gun) or engage in a high speed driving chase. He feels unable to physically control an unruly perpetrator and is discouraged by his limitations.

Mr. Wilson has never been treated or evaluated by a mental health professional and readily admits experiencing anxiety or "worry" about losing his job or even being near a taser gun. He explained that his fellow officers will jokingly aim the laser beam from the

taser gun at him while he is sitting at his desk dispatching. The sight of the red dot causes immediate panic or anxiety. Prior to the taser accident, Mr. Wilson acknowledges being afraid of electricity and was very worried about participating in the test.

Further, he is perplexed as to how mental health treatment or "talking" could help his problems. In addition, he denies experiencing auditory or visual hallucinations, delusional thinking or suicidal/homicidal ideation.

Social History/Daily Activities. Mr. Wilson denies having ever been arrested and convicted of a misdemeanor or felony, estimates drinking 12 beers/week and has used no illegal drugs since his teenage years. Further, he has been married to his first wife for 26+ years, and his 20-year-old son lives with them. He denies experiencing any marital conflicts but has problems with sexual impotency and will discuss these issues with his treating physician at his yearly physical exam in June.

Mr. Wilson completes all laundry chores, cooks the evening meal and cleans the kitchen. He does not engage in any yard, house or auto maintenance tasks and spends most of his nonworking time visiting friends, completing errands for his family and occasionally traveling. He is not an avid reader and does not watch much TV.

Clinical/Behavioral Observations/Mental Status. Mr. Wilson is 5'10" tall, weighs 175 lbs. and appeared casually/cleanly dressed. He had a day's growth of beard, wore a ball cap which he did not remove and was also wearing a pair of Rx glasses. He was always cooperative, polite and somewhat reserved. He is a soft-spoken individual who became quietly tearful when discussing the taser accident and his worries about his job security. His affect was subdued, and his mood was noticeably depressed and anxious. Further, he has little psychological insight or mindfulness but good judgment.

His speech was articulate and occasionally terse, and his thoughts were logical but somewhat concrete and included many irrelevant details. He appeared obsessed by his pain and physical malfunctioning; however, he did not display histrionic pain behavior but did on occasion shift from one hip to the other while seated and stood once during the clinical interview. He did not moan, groan, vigorously rub his back or stand and sit like a jack-in-the-box.

Psychological Test Results. Mr. Wilson was administered the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and his test results are summarized below:

(a) Mr. Wilson was honest and forthright in answering the test questions and did not attempt to overstate or exaggerate his emotional problems. All of the Validity Scales were within normal limits. Hence, the results of the clinical testing is a valid assessment of his current psychological status and problems.

(b) Mr. Wilson has many of the symptoms of subjective depression and therefore feels nervous and tense most of the time, lacks self-confidence and feels generally unhappy and blue. He feels mentally dull and at times overwhelmed by the problems of everyday life.

(c) Mr. Wilson is also a chronically anxious and apprehensive individual who feels insecure, uncomfortable in making decisions and is somewhat obsessive-compulsive.

In addition, Mr. Wilson is a somewhat phobic, ruminative and overideational person who has developed passive-aggressive personality traits and is often privately angry and frustrated. However, he is also a dependent individual and will not likely have frank and open discussions about his psychological problems and unmet needs. Instead, Mr. Wilson will use alcohol to decrease his intense anxiety and discomfort.

(d) Mr. Wilson is not likely to benefit from traditional psychotherapeutic intervention. He will not be able to tolerate the increased anxiety that this process causes and may terminate treatment prematurely. He is not psychologically mindful and will not appreciate the severity of his problems or how they can be helped by "talking" about them. He also believes that he has concerns that cannot be shared with anyone. Nonetheless, Mr. Wilson currently feels intense emotional distress.

Diagnoses. **(DSM-IV)**

Axis I:	300.02	Generalized Anxiety Disorder
	304.4	Dysthymic Disorder, Late Onset
Axis II:	301.9	Personality Disorder NOS (with dependent and passive-aggressive features)

Recommendations.

1. Mr. Wilson is not faking or malingering his emotional problems. He has always been a chronically anxious individual who has struggled to overcome his strong sense of dependency and fear of failure; however, he was able to adequately perform all of the job duties as a state patrolman until his injury.

He admits having anticipatory anxiety prior to the exposure to the taser gun and being an unwilling participant. Hence, he was physically tense and frightened at the time of the exposure which certainly increased the probability of an emotional and/or physical injury.

Currently, his intense anxiety and emotional distress will preclude his reliably performing all of the duties of a highway patrolman. He will be hyper alert, intensely frightened and fearful in any emergency situation and will unavoidably endanger himself or those citizens with whom he comes in contact during the execution of a crime or serious legal violation. Mr. Wilson will be uncertain in situations that demand a quick, confident and decisive response, and he will likely use bad judgment because of fear. He lacks the confidence to do his job.

2. Mr. Wilson may be abusing alcohol as a way of self-medicating, and he needs help in understanding the inappropriateness of his drinking behavior. Instead, he should be taking psychotropic medication to better control his symptoms. He would benefit most from a direct, goal-oriented treatment approach as opposed to traditional psychotherapeutic intervention. He should consult with a psychiatrist who can manage his medication and offer concrete and practical strategies which Mr. Wilson can use to feel more confident and less anxious. For example, he would benefit from consulting with Dr. Frank Pratt, a Cartersville psychiatrist. Dr. Pratt often consults with individuals who are employed in law enforcement and is aware of the demands and stresses of that type of work.

3. Further, the clinical test results indicate that Mr. Wilson is not the kind of person who will convert emotional difficulties into physical or somatic problems. There is no evidence from the test results that he is a conversion hysteric or likely to confabulate his physical complaints. While he is worried about his pain and discomfort, Mr. Wilson is not preoccupied with it.

Again, I appreciate your asking me to evaluate Mr. Wilson and hope that this information will be of help to you in your work with him.

Very sincerely,

Richard D. Hark, Ph.D.
Licensed Psychologist

RDH:kb

Transcribed & mailed: April 29, 2005

MMPI-2 Minnesota Multiphasic Personality Inventory-2™

Profile for Validity and Clinical Scales

Name _____

Address _____

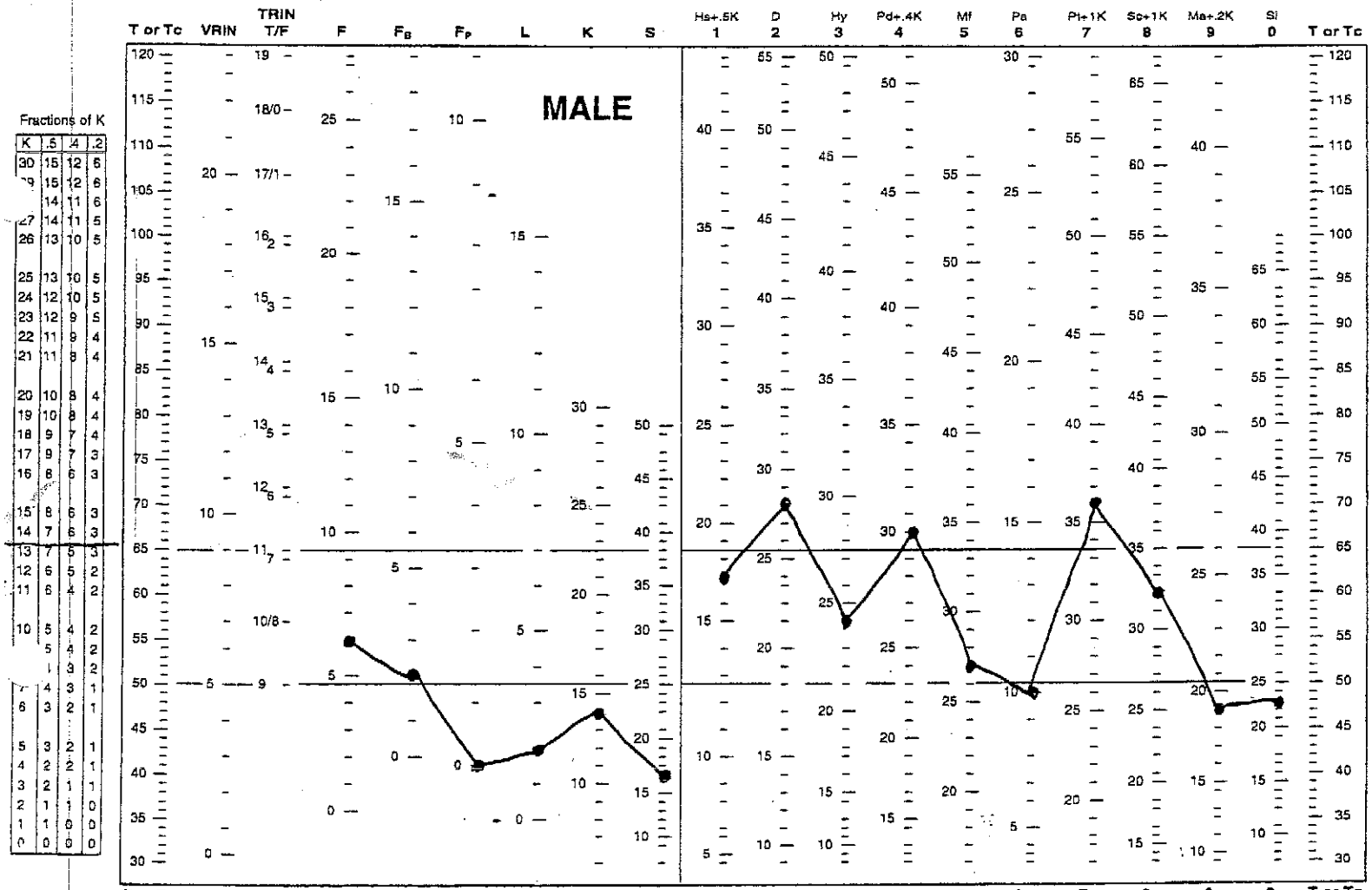
Occupation _____ Date Tested 4/29/05

Education _____ Age _____ Marital Status _____

Referred by _____

MMPI-2 Code _____

Scorer's Initials _____



Fractions of K

K	.5	.4	.2
30	15	12	6
29	15	12	6
28	14	11	6
27	14	11	5
26	13	10	5
25	13	10	5
24	12	10	5
23	12	9	5
22	11	9	4
21	11	8	4
20	10	8	4
19	10	8	4
18	9	7	4
17	9	7	3
16	8	6	3
15	8	6	3
14	7	6	3
13	7	5	3
12	6	5	2
11	6	4	2
10	5	4	2
9	5	4	2
8	4	3	2
7	4	3	1
6	3	2	1
5	3	2	1
4	2	2	1
3	2	1	1
2	1	1	0
1	1	0	0
0	0	0	0

	T or Tc	VRIN	TRIN / T/F	F	FB	FP	L	K	S	1 Hs+.5K	2 D	3 Hy	4 Pd+.4K	5 Mf	6 Pa	7 Pt+1K	8 Sc+1K	9 Ma+.2K	0 Si
Raw Score				6	2	0	2	14	16	10	28	24	24	27	10	22	18	16	23
? Raw Score																14	14	3	
K to be Added										7			6						
Raw Score with K										17			30			36	32	19	

WMR 0004

NCS Assessments™

Product Number 24001

MMPI-2™ Minnesota Multiphasic Personality Inventory-2™

Name David Wilson

Harris-Lingoes and Si Subscales Score Record

MALE

Raw Score	D_1	D_2	D_3	D_4	D_5	Hy_1	Hy_2	Hy_3	Hy_4	Hy_5	Pd_1	Pd_2	Pd_3	Pd_4	Pd_5	Pa_1	Pa_2	Pa_3	Sc_1	Sc_2	Sc_3	Sc_4	Sc_5	Sc_6	Ma_1	Ma_2	Ma_3	Ma_4	Si_1	Si_2	Si_3	Raw Score
30	116								120										120													—
	114								116										117													—
	111								111										113													—
	108																		109					120						86	—
	106							106											105					119						83	—
25	103																		101					114						80	—
	100							102	106							120			97			114		109				77		77	—
	98	98		105										98		118			92			109		104				74		74	—
	95	92		101				97	101					92	91	112			88			103		99				71		71	—
	93	87		96			71	93	96					87	87	106			84			98	117	95		78		68		68	—
	90	81	116	91			67	88	91					82	82	100			80		103	92	110	90		73		65		65	—
20	87	76	108	86	96		63	84	86					77	77	94	95	70	76	120	96	87	103	85		68	89	62		62	—
	85	70	100	82	91		59	79	82		98			71	72	88	89	65	72	117	90	82	96	80		63	77	82	59	71	59	—
	82	65	91	77	85		55	75	77		91	80		66	67	82	82	60	68	107	84	76	89	75		58	71	76	56	67	56	—
	79	59	83	72	79		51	70	72	78	84	73		66	67	82	82	60	68	107	84	76	89	75		58	71	76	56	67	56	—
	77	54	75	67	74	61	47	66	67	71	78	67	63	61	63	76	75	56	64	98	78	71	82	70	81	53	65	69	54	62	53	—
	74	48	67	62	68	56	43	61	62	63	71	60	57	56	58	70	68	51	59	88	72	65	75	65	74	49	59	63	51	58	50	—5
	71	43	59	58	62	51	40	57	57	55	65	53	51	50	53	64	62	46	55	78	66	60	68	60	66	44	53	56	48	54	47	—
	69	37	51	53	57	45	36	52	52	48	58	47	45	45	48	58	55	41	51	69	60	55	61	55	58	39	47	50	45	49	44	—
	66	32	43	48	51	40	32	48	48	40	51	40	39	40	43	52	48	36	47	59	54	49	54	51	50	34	41	43	42	45	41	—
	64	30	35	43	45	34	30	43	43	33	45	33	33	35	38	46	41	32	43	50	48	44	47	46	42	30	35	37	39	41	38	—
15	61																															
	58																															
	56																															
	53																															
	50																															
	48																															
	45																															
	42																															
	40																															
	37																															
	35																															
10	32																															
0																																

Raw Score	D_1	D_2	D_3	D_4	D_5	Hy_1	Hy_2	Hy_3	Hy_4	Hy_5	Pd_1	Pd_2	Pd_3	Pd_4	Pd_5	Pa_1	Pa_2	Pa_3	Sc_1	Sc_2	Sc_3	Sc_4	Sc_5	Sc_6	Ma_1	Ma_2	Ma_3	Ma_4	Si_1	Si_2	Si_3	Raw Score
Raw Score	13	6	5	7	2						3	3	6	6	6																	
T Score																																

NCS Assessments™

MMPI-2™ Minnesota Multiphasic Personality Inventory-2™

Profile for Supplementary Scales

Name David Wilson

Address

Occupation Date Tested 4/29/05

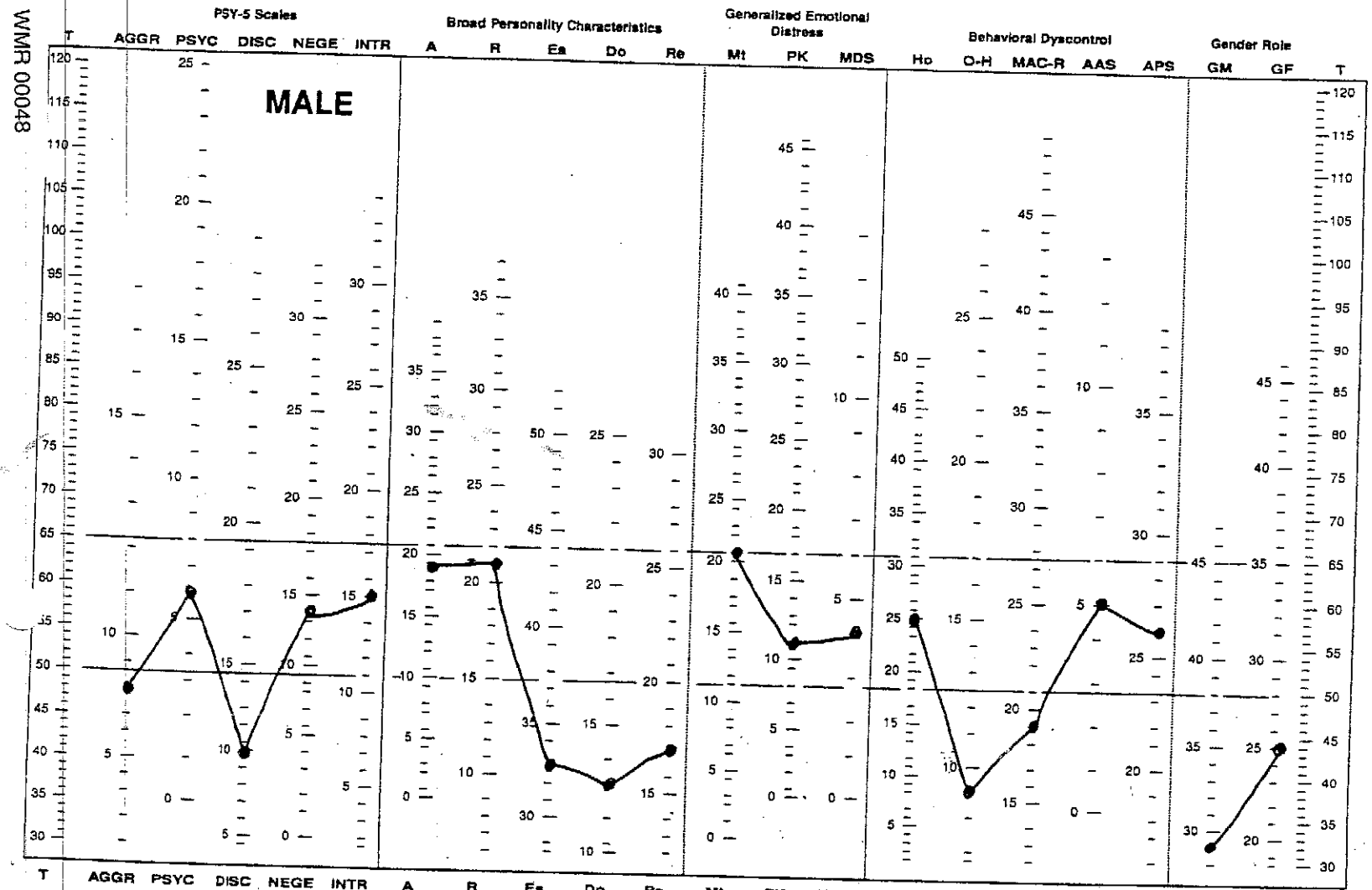
Education Age Marital Status

Referred by

MMPI-2 Code

Scorer's Initials

WMR 00048



	T	AGGR	PSYC	DISC	NEGE	INTR	A	R	Es	Do	Re	Mt	PK	MDS	Ho	O-H	MAC-R	AAS	APS	GM	GF	T
Raw Score		8	6	10	14	15	19	21	33	13	17	21	11	4	25	9	19	5	26	29	25	

PEARSON Assessments

Product Numbe

MMPI-2 Minnesota Multiphasic Personality Inventory-2™

Profile for Content Scales

Address _____

Occupation _____ Date Tested _____

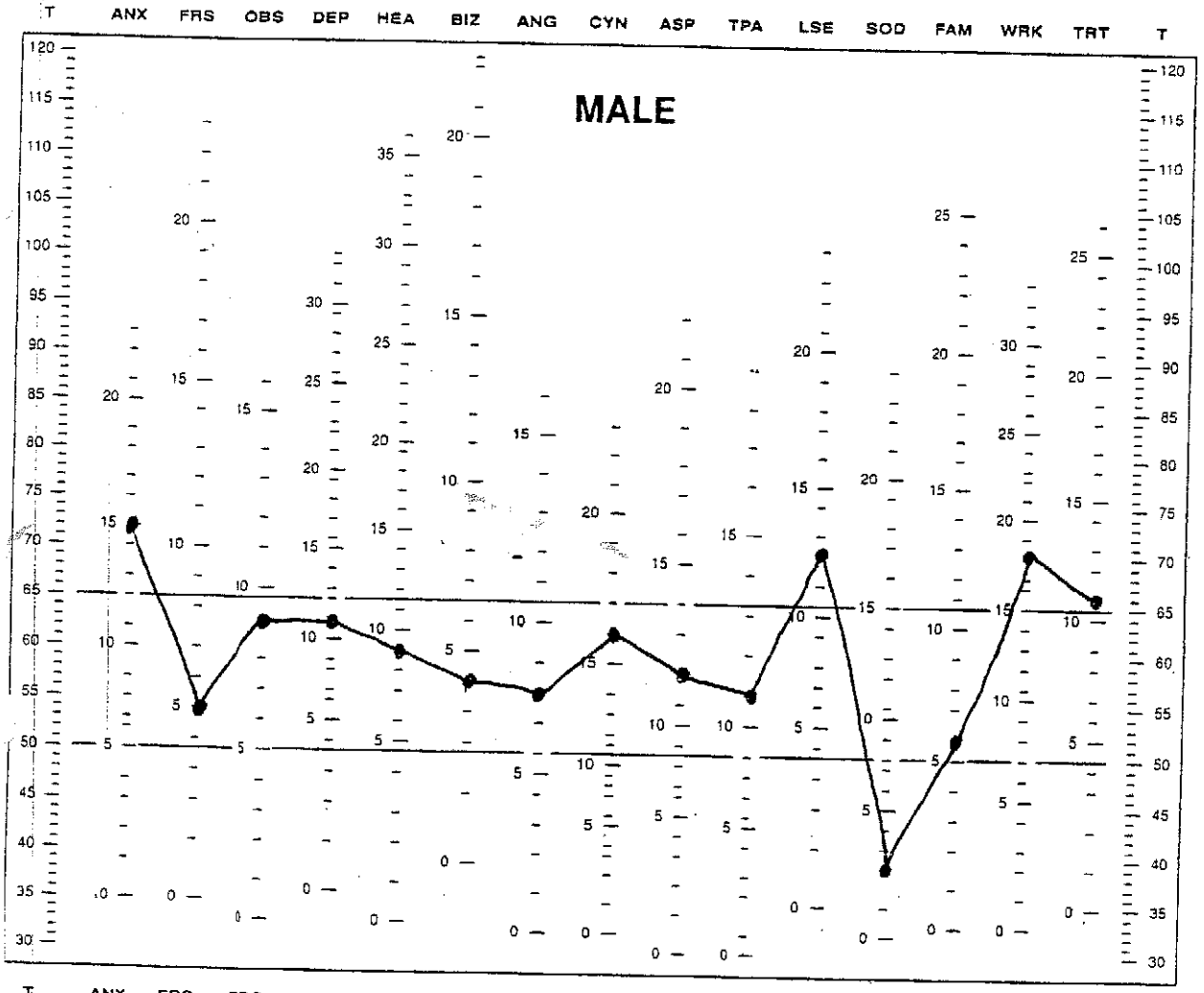
Education _____ Age _____ Marital Status _____

Referred by _____

MMPI-2 Code _____

Scorer's Initials _____

857-3441
Lorena



	T	ANX	FRS	OBS	DEP	HEA	BIZ	ANG	CYN	ASP	TPA	LSE	SOD	FAM	WRK	TRT	T
Raw Score		15	5	9	11	9	4	8	16	12	11	12	2	6	18	11	

PEARSON Assessments
Product Number 24002

IN THE STATE BOARD OF WORKERS COMPENSATION

STATE OF GEORGIA

DAVID WILSON, Employee/Claimant, v. GEORGIA STATE PATROL and DEPARTMENT OF ADMINISTRATIVE SERVICES, Employer/Insurer.	*	CLAIM NO. 260-94-5083 S&S: 244.0101339 **ENCLOSE RECORDS FOR ALL TREATMENT DATES**

WORKERS' COMPENSATION
REQUEST FOR PRODUCTION OF DOCUMENTS

TO: Medical Records Custodian
Dr. Michael Jackson
Redmond Family Care
2304 Shorter Ave.
Rome, GA 30165

ok to release MJ

1.

I herewith serve upon you the following Request for Production of Documents pursuant to the provisions of Sec. 34 of the Georgia Civil Practice Act (O.C.G.A. §9-11-34), and of the Georgia Workers Compensation Act (O.C.G.A. §34-9-207).

2.

You are hereby requested and required by law to produce the documents hereinafter set forth to **WALLACE SPEED,** Speed & Seta, LLC, 114 Stone Mountain Street, Lawrenceville, GA 30045, within thirty (30) days as prescribed by law, or you may comply with this request by mailing certified copies of the documents hereinafter set forth to **WALLACE SPEED** at the above address.

SPEED&SETA, LLC
ATTORNEYS AT LAW
4 STONE MOUNTAIN ST.
LAWRENCEVILLE, GA 30045
(770) 822-2911
FAX (770) 822-2912

5/23/05 - all records mailed BA

3.

This request for medical records involves the workers compensation claim shown above and is therefore NOT-PRIVILEGED. (See O.C.G.A. §34-9-207).

4.

You are requested and required to produce certified copies of any and all medical records including, but not limited to, clinical reports, history, medical reports, evaluations, physicians notes, and all other information pertaining to **David Wilson (Social Security No. 260-94-5083).**

Please mail the requested items to: WALLACE SPEED, ESQ., Speed & Seta, LLC, 114 Stone Mountain Street, Lawrenceville, GA 30045.

WALLACE SPEED
Georgia Bar No. 670600
Attorney for Employer/Insurer

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I have this day served the foregoing Request for Production of Documents upon the following parties by depositing a true and correct copy thereof in the United States Mail with adequate postage thereon to ensure delivery, and addressed as follows:

Miles Gammage, Esq.
P.O. Box 930
Cedartown, Georgia 30125

This 16th day of May, 2005.

WALLACE SPEED

SPEED & SETA, LLC
ATTORNEYS AT LAW
114 STONE MOUNTAIN ST.
LAWRENCEVILLE, GA 30045
(770) 822-2911
FAX (770) 822-2912

CELL 770-3[illegible] 3351 **HCA PHYSICIAN SERVIC[illegible]** 770-684-3305 Call when ready

Redmond Family Care Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the PHI be created for research and include treatment of the patient?
If yes, complete the Authorization for Research Form. If no, skip to Section B.

Section B: This section must be completed for all Authorizations for Release of PHI or Right to Access

Patient Name: DAVID R WILSON	**Birth Date:** 01 19 57	**Social Security No. *(optional)*:** 260945085
Patient's Address: 85 AYERS RD	**Requestor's Name/Phone Number (if patient is not the requestor):**	
Recipient's Name:	**Address** 85 AYERS RD	
	City: ARAGON	**State:** GA **Zip:** 30104

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: 04 04 05 **Event:**

Purpose of Disclosure:

Description of information to be used or disclosed

Is this request for **psychotherapy notes?** ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI in medical record ☐ History and Physical ☐ Consult Report ☐ Operative Report ☐ Progress Notes		☐ Physician Orders ☐ Laboratory ☐ Imaging/Radiology ☐ Nursing Notes ☐ Medication Record		☐ Demographics ☐ Rehabilitation Services ☐ Special Test/Therapy ☐ Itemized Bill ☐ Claim Forms ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary. If I refuse to sign, my records can not be released.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Is the Requester of this PHI another health plan or health care provider?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

What is the purpose of this use or disclosure?

Will the requester receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:

Section D: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative: David R Wilson	**Date:** 04/04/05
Print Name of Patient's Representative:	**Relationship to Patient:**

WMR 00052

Original – Practice
Copy – Patient
Copy – Recipient

HIM.PRI.001 - Authorizations

Revision Date: March 12, 2003

4/11/05 - all records copied to pt - BA

Trust · Excellence · Service

Department of Administrative Services

Risk Management Services
Elaine Townes, Director

February 23, 2005

Michael Jackson, M. D.
Redmond Family Care
2304 Shorter Ave.
Rome, Ga. 30165

Re: Employee: David R Wilson
Claim Number: WC05531736
SSN: 260-94-5083
Date of Loss: 09/07/2004
Nature of Injury: Thoracic spine compression fracture following taser gun injury

Dear Dr. Jackson:

We acknowledge receipt of Dr. Soctt Bowerman's IME/consultation report dated 12/10/04. On February 23, 2005, we informed Dr. Scott Bowerman the referral to Dr. Richard Hark (psychologist) would not be authorized, since he was not the primary care physician.

We would like to inform you, David R. Wilson has returned to work with the Georgia State Patrol as a radio operator for now. On Mr. Wilson's next follow up appointment we would appreciate your addressing the following questions and return this letter :

1. When do you anticipate David R. Wilson reaching maximum medical improvement as a result of his injury he sustained on 9/07/04 ?

2. When will David Wilson be able to return to his regular job as a State Trooper ?

3. Will there be restrictions? If so, are the restrictions permanent ?

Thank you for your assistance.

Sincerely,

Bayonne Starks
Workers' Compensation Specialist

WMR 00053

Billing Info:
State of Georgia /DOAS
PO. Box 38198 Capital Hill Station
Atlanta, GA 30334-9010
Toll:877-657-7475 Fax: 404-656-9178

STATE OF GEORGIA
DEPARTMENT OF
ADMINISTRATIVE SERVICES
RISK MANAGEMENT

To: Redmond Occupational Health Attn: Cathy Daniels **From:** Denise Goodman (Triage Analyst)

Fax: 706-233-4006 **Pages:** (includes cover page) 1

Phone: **Date:** 3/29/05

Re: David Wilson **CLAIM#** WC 05531736

X Attach Medical Note

Please fax detailed medical records for this employee for the State of Georgia. Please complete the form listed below with Mr. Wilson's work status. Thanks, Denise

Date of Last Office Visit 11/16/04 Next Office Visit No follow up - Referred to Orthopedic specialist

Diagnosis T6 -T8 Compression fracture Prognosis _____

WORK STATUS: (please check)

Full Duty _____ No Work _____ Discharged from Care_____ Date_____

If not at Full Duty, can injured work return to **Modified Work** at this time? YES NO
What are the restrictions? _____

Is the injury/diagnosis caused/aggravated by an employment activity? YES NO

Is Injured Worker at **Maximum Medical Improvement**? YES NO
If no, please provide estimated timeframe. _____ PPD Rating? YES NO %_____

Treatment Plan / Recommendation _____

Physician Signature Michael S. Jackson, MD Date: 3/30/05

3/30/05 This patient was referred to Dr. Scott Bowerman for further treatment. His last office visit here was 11/16/04.

FAXED 3/30/05

WMR 00054

ORTHOPAEDIC AND SPORTS MEDICINE CENTER

1013 North 5th Avenue • Suite 7 • ROME, GEORGIA 30165
(706) 292-0040 • FAX (706) 378-0556

SCOTT G. BOWERMAN, M.D.
SPORTS MEDICINE AND
GENERAL ORTHOPAEDICS

THOMAS T. DOVAN, M.D.
HAND, UPPER EXTREMITY
AND GENERAL ORTHOPAEDICS

CHARLES B. MAY, JR., M.D.
SPORTS MEDICINE AND
GENERAL ORTHOPAEDICS

December 10, 2004

Michael Jackson, MD
2304 Shorter Ave
Rome, GA 30165

RE: David Wilson
ACCT#: 63691
DOB: 01/19/57

Dear Dr. Jackson:

I saw your patient, David Wilson, in my office today for an orthopaedic consultation. Thank you for asking me to see him.

As you will recall, he is a 47-yr-old gentleman who has been working for the GA State Patrol for approx. 19 yrs. He presents for an evaluation of a work injury that is very unusual. As a state patrol officer, there has been a policy that he should be subjected to a taser gun. This was done on 09/07/04, and this caused him to be hospitalized because of pain in his back. He spent a day in the hospital in Forsyth, and apparently, his workup was negative, but recently, an MRI scan has shown a compression fracture at T6 and T8 on 11/09/04. He presents now for an orthopaedic consultation.

He's still having some aggravating discomfort and pain in his upper thoracic spine. He states there are times that he seems to be feeling better, but then there are some times when he sneezes or coughs, and he feels some pain between his shoulder blades. He denies any neck pain or numbness. There is occasional radiating pain on the L side of his chest below his nipple. He has managed to return to light duty work as a radio operator for the State Patrol. He tried PT, but that seemed to increase his pain.

PAST MEDICAL HISTORY: History of acid reflux, cataracts.

ALLERGIES: None.

CURRENT MEDICATIONS: Ibuprofen, recent use of Lorcet prn.

SOCIAL HISTORY: He is married w/ children. He denies tobacco use and reports weekly alcohol use.

PHYSICAL EXAMINATION: WT-191, HT-5'9". Inspection of his back reveals good alignment and symmetry. He has mild discomfort on fist percussion. There is no abnormal alignment. He was able to raise both arms overhead w/ good strength of rotator cuff function. SLR test was negative. Reflexes were symmetric bilaterally, 2+ patella tendon. There is no clonus. He walks w/ out a limp.

IMPRESSION: Thoracic spine compression fractures following taser gun injury.

I had concerns today after talking w/ Mr. Wilson that mentally he has been affected deeply by this accident. He was very reluctant to undergo the test, and he still seems emotionally effected by the injury that occurred 3 months ago. I recommend that he have some sort of counseling setup for him. I've also recommended that PT be held until his next visit in 1 month when I will recheck plain x-rays of his thoracic spine. It is ok for him to continue working the radio, which I think will be helpful for him to transition back to his regular job. I expect a 6-month time course of recovery from this injury.

Please call me if you have any questions regarding his evaluation. Again thank you for asking me to see him.

Sincerely,

Scott G. Bowerman, MD

SB/kn

Redmond Occupational Health
Experts in Healthcare, Neighbors for Life!

Specialty Network Provider Referral Form

(For questions or assistance, call Kay Dixon, B.S., R.N., C.W.C.P., Injury Manager, at 706-290-8012.)

This patient is referred to you for: ☐ **Consultation & Recommendations Only** ☐ **Evaluation & Treatment**

PATIENT INFORMATION

Referred To: Dr Bowerman Referred By: Michael Jackson Appt. 12-7-04 7:30

Reason for Referral: Compression FX Authorized By: Deborah Cook

PATIENT/EMPLOYEE	EMPLOYER	CARRIER
NAME: David Wilson	NAME: State of GA	NAME: Risk Mgt.
DOI: 9-7-04	CONTACT: Lisa	CONTACT: Deborah Cook
DOB: 1-19-57	PHONE: 770-324-3351	CLAIM # (if assigned) WC0553136
SS#: 260-94-5083	FAX:	PHONE: 404-656-9497
PHONE: 770-684-3305	ADDRESS: 1300 Jefferson Davis	ADDRESS: 200 Piedmont Ave
ADDRESS: 85 Ayers Rd	Cartersville GA 30120	Ste 1208 West Tower - Atl GA 30334
Aragon GA 30104	Description of Accident:	

DEAR PHYSICIAN: Please complete and fax this form within four (4) hours of your evaluation to (706) 290-8518.

PHYSICIAN INFORMATION

Diagnosis: _____

Recommendations/Treatment/Medications: _____

R.T.W. Disposition:

- ☐ Regular Work — As of: _____
- ☐ Temporary Modified — From: _____ To: _____
- ☐ Bed Rest — From: _____ To: _____
- ☐ MMI Achieved: _____

☐ **Re-check:** Date: _____ Time: _____

- ☐ No Follow-up Needed
- ☐ Physical Therapy-R.R.M.C.-P.T.
- ☐ X-ray / MRI / C.T. / NCV / EMG
- ☐ Surgery

All Surgical, Ancillary & Diagnostic Procedures not provided at Specialty Network Provider Site must be performed at Redmond Facility.

Physical Capabilities: _____

In an 8-12 hour work day, employee can:	Constantly (67-100%)	Frequently (33-66%)	Occasionally (0-33%)	Not at All
Stand/Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Drive	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Perform Work at Shoulder Level	☐	☐	☐	☐
Perform Repetitive Motions	☐	☐	☐	☐
Perform Overhead Work	☐	☐	☐	☐

Employee is able to lift no more than: ☐ 0-10 lbs. ☐ 10-25 lbs. ☐ 25+ lbs.

Comments: _____

Physician Signature: _____ Date: _____

WMR 00057

Sender's Name: _____

WHITE COPY: FAX to Injury Manager - Specialist Retains / YELLOW COPY: Employer Via Patient

Phone: 404-463-6308
Fax: 404-656-9178

Rochelle Riley
Medical Management
MCO Nurse
State of Georgia
Department of Administrative Services
P.O.Box 38198, Capitol Hill Station
Atlanta, Georgia 30334-9010

Date: 10/06/04

'Dr. Meier

Our injured worker David Wilson/WC05531736 has been treating with you for his work related injury. Last update received was dated 09/10/04. We need the following information to address continued Workers' Comp benefits for your patient.

Date of **Last Office Visit** 10/5/04 **Next Office Visit** 10/19/04

Diagnosis Improving Back Pain.

Current Treatment Plan Work Hardening Evaluation + Recheck.

PROGNOSIS Good.

WORK STATUS: (please check)

No Work _____

Full Duty Release V **(DATE)** 10/6/04

If not at Full Duty, can injured work return to **Modified Work** at this time? YES NO

Is injury/diagnosis work related? (YES) NO

What are the **restrictions?** N/A

Is Injured Worker at **Maximum Medical Improvement?** YES (NO)
If no, please provide estimated timeframe. _____

What is PPD rating? _____

Physician Signature Edward Meier Date 10/6/04

FAXED
10/6/04
BA

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

OSHA File No.:
Insurer File No.: WC05531736

Employer: Dept Of Public Safety	Employer Phone No.	Insurer/Self Insurer Name: DOAS Risk Management, State of Georgia	TPA/Claims Office
Address: PO BOX 1456		Employer FEIN	TPA FEIN
City: Atlanta / State/Zip: GA 30371-	Nature of Business (Mfg., Trade, Transp., Etc.)		Address
Employer Location Address (If Different): Po Box 1456		City: Atlanta / State/Zip: GA 30316	City / State/Zip
Place of Accident or Exposure (Address or Location): GEORGIA PUBLIC SAFETY TRAINING		Job Classification Code: SENIOR TROOPER	TPA/Claims Office Phone No.
Employee Name (Last) (First) (Middle): Wilson, David R		Date of Birth: 01/19/1957	County of Injury: Monroe
Address: 85 Ayers Rd.		Date of Injury: 09/07/2004	Employee Social Security Number: 260945083
City: Aragon / State/Zip: GA 30104	Employee's Home Ph. #: 770 684-3305	Number of Dependents Including Spouse: 2	DO NOT WRITE IN THIS COLUMN

Male ○ Female ○	Time of Injury: 10:00 am	Time Workday Began	Date Employer Notified: 09/07/2004	Insurer No.
Date Hired: 06/16/1985	Did Employee Work the Next Day? Yes ○ No ○	First Date Employee Failed to Work a Full Day: 09/07/2004	Did Employee Receive Full Pay for Date of Injury? Yes ● No ○	SIC / Date of Birth
Hours Worked Per Day (8) Per Week (40)	Number of Days Worked Per Week(5	List Normally Scheduled Off Days: Sat, Sun	Wage Rate at Time of Injury or Disease: [redacted] Hour ○ Day ○ Week ○ Mo. ○	Sex / County of Injury
COMPLETE WAGE STATEMENT ON REVERSE: If employee is paid hourly, on commission or piecework basis, enter average weekly amount $		If board, lodging, or other advantages were furnished, enter average weekly amount $		Employer Aware
Did Injury/ Illness Exposure Occur on Employer's Premises? Yes ● No ○		Type of Injury/Illness: Unclassified - Insufficient D	Part of Body Affected: Back	Nature / Body Part / Cause

How Injury or Illness / Abnormal Health Condition Occured. What was employee doing just prior to the accident?
Callec stated he was in a taser stun gun class, when he was shot with the taser gun. This resulted in an unspecified inj

If Returned to Work, Give Date: 00/00/0000	Returned at What Wage per Week	If Fatal: Give Date of Death	Job Classification Code / M.O. / Controvert / D. First
Treating Physician (Name and Address): HARBIN CLINIC Unk Dr. Tim Connor Unk, GA	Initial Treatment: ○ No Treatment ○ Minor: By Employer ● Minor: Clinic/Hospital ○ Emergency Care ○ Hospitalized >24 hrs. MCO Yes ○ No ●	Hospital/Treating Facility (Name and Address): UNK Unk Unk Forsyth, GA	

Report Prepared By (Print or Type)	Position	Telephone Number	Date of Report
Wilson, David	SENIOR TROOPER	(770) 324-3351	09/08/2004

EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY

B. FOR USE BY INSURER/SELF-INSURER

Average weekly wage: $ _____ Weekly benefit: $ _____ Date of disability: _____ Date of first payment: _____
Compensation paid: $ _____ Penalty paid: $ _____ Previously Medical Only Yes ○ No ○
BENEFITS ARE PAYABLE FROM _____ FOR:
☐ Total/temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of ___% to _____ Part of Body ____ eeks
UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

By _____ ( ) -
(Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extension)

C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION (over for additional information)

Benefits will not be paid because:

By _____ ( ) -
(Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extension)

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation(O.C.G.A.. s34-9-18 and s34-9-19).

10-5-04

ADVANCE REHABILITATION

Patient: David Wilson

Physician: Dr. Conner

Date: 10-04-04 Total Visits: 6

Patient Status: Pt. has attended 6 PT visits for T/S paraspinal spasms 2° Taya shock.
Good progression. Pt. reports spasms have stopped however soreness cont's especially c physical activity such as washing vehicle & running.
Strength (B) UE's ↑'d to 5/5
↓'d TTP & muscle guarding.
Pt. not working at this time.
Has not attempted pushups. Pt. concerned about having to run p person or having physical confrontation.

P.T. Recommendations: Pt. would benefit from Work Hardening to prepare for return to work due to physical nature of job if need arises.
Please advise. Thank you!

Frequency / Duration: _____

P.T.: Melia Kesmitopa M.D.: _____

Advance Rehabilitation of Rome
201 Turner McCall Blvd.
Rome, Georgia 30165
Phone: (706) 235-2727
Fax: (706) 235-2726

Advance Rehabilitation of Cedartown
1108 North Main Street
Cedartown, Georgia 30125
Phone: (770) 749-0250
Fax: (770) 749-0086

Advance Rehabilitation of Chattooga
11638 Highway 27, Suite 1
Summerville, Georgia 30747
Phone: (706) 857-6366
Fax: (706) 857-6372

Advance Rehabilitation of Rockmart
115 Felton Drive
Rockmart, Georgia 30153
Phone: (678) 757-1899
Fax: (678) 757-1898

Redmond Physical Therapy

Experts in Healthcare, Neighbors For Life!

610 Shorter Avenue, Suite 20 • Rome, Georgia 30165
Phone: (706) 236-1911 • FAX: (706) 236-1908

Patient Name: David Wilson **Appointment Date:** _____

Diagnosis: s/p Back surgery ICD-9 Code: _____ **Appointment Time:** _____

Precautions or special instructions: 20 lb Lazor shark

See 2-3 **times a week for** 2 **weeks** ✓ **Evaluate and treat as indicated:**

Modalities:

- _____ Cryotherapy - 66720
- _____ Electrical Stimulation - 97014
- _____ Gait Training - 97116
- _____ Hot Packs - 97010
- _____ Iontophoresis - 97033
- _____ Joint Mobilization - 97140
- _____ Jobst Compression - 97012
- _____ Taping
- _____ Dressing - 16020
- _____ Massage - 97124
- _____ ROM Exercise - 95833
- _____ TENS - 64550
- _____ Therapeutic Exercise - 97110
- _____ Traction - 97012
- _____ Ultrasound - 97035
- _____ Whirlpool - 97022
- _____ Biofeedback - 90901

Women's Health:

- _____ Biofeedback Training/Muscle Re-education - 90901
- _____ Soft Tissue Mobilization/Trigger Point Release - 97140
- _____ Biobehavioral Patient Education - 99078
- _____ Therapeutic Exercise - 97110
- _____ Jobst Compression - 97012
- _____ OB/GYN Therapeutic Exercise - 97110
- _____ OB/GYN Posture/Positioning Re-education
- _____ Osteoporosis Program

Testing:

- _____ Functional Capacity Evaluation - 97750
- _____ Kin-Com Evaluation - 97750
- _____ Musculoskeletelal Assessments - 97001

Special Programs:

- _____ Back School
- _____ Job Site Evaluation
- _____ Spinal Stabilization
- _____ Lymphedema Program
- _____ TMJ
- _____ Work Hardening - 97545
- _____ Diabetic Foot Care
- _____ Aquatic Rehabilitation - 97113

Outpatient services located at Redmond Regional Medical Center / Inpatient PT Department (706) 802-3160:

- _____ Speech Therapy - 92507
- _____ Pediatric Therapy
- _____ Occupational Therapy-97003
- _____ Hand Therapy

I hereby certify these services as medically necessary for the patient's plan of care.

Physician Signature: _____ **Date:** 4/10/04

cell # 770-324-3351
h/ 770-684-3305

REFERRAL REQUEST

PATIENT'S NAME: David Wilson

REFER TO: MRI

DIAGNOSIS CODE (MUST HAVE): Chronic Thoracic muscle pain + (Mid thoracic back weakness pain)

APPOINTMENT DATE & TIME: _____

PATIENT NOTIFIED: _____

RECORDS FAXED: _____

Carrier Schedules Apt

DMS 53016534 (R 8/00)

ADVANCE REHABILITATION

Patient: David Wilson

Physician: Dr. Meier

Date: 10/28/04 Total Visits: 12

Patient Status: Pt. has attended a total of 12 PT visit, 6 visits since 10/15/04.

Continues to c/o (L) T/S & mid T/spine pain especially c lifting objects away from body. Pain c getting cornbread from oven, wet clothes from washer, lifting bag of dog food - all requiring T/S flexion. Pain c overhead activity over 30 seconds & lifting objects overhead.

I'd (R) T/S Rotation & pain on (L) T/S c (R) Rotation

RX Consisted of Therex/stretches, Ultrasound, Moist heat, Cold packs & Estim.

P.T. Recommendations: Cont PT c emphasis on fine functional lifting & movements & controlling pain.

Please advise, Thank you!

Frequency / Duration:

WMR 00062

P.T.: Melica Roshuto PTA M.D.:

Rome
201 Turner McCall Blvd.
Rome, Georgia 30165
Phone: (706) 235-2727
Fax: (706) 235-2726

Cedartown
1108 North Main Street
Cedartown, Georgia 30125
Phone: (770) 749-0250
Fax: (770) 749-0086

Chattooga
11638 Highway 27, Suite 1
Summerville, Georgia 30747
Phone: (706) 857-6366
Fax: (706) 857-6372

Rockmart
115 Felton Drive
Rockmart, Georgia 30153
Phone: (678) 757-1899
Fax: (678) 757-1898

Adairsville
10 Legacy Way, Suite E
Adairsville, Georgia 30103
Phone: (770) 773-9315
Fax: (770) 773-9317

Calhoun
263 Highway 53
Calhoun, Georgia 30701
Phone: (706) 773-9315
Fax: (706) 773-9317

Redmond Occupational Health
Experts in Healthcare, Neighbors for Life!

Specialty Network Provider Referral Form

(For questions or assistance, call Kay Dixon, B.S., R.N., C.W.C.P., Injury Manager, at 706-290-8012.)

This patient is referred to you for: ☐ **Consultation & Recommendations Only** ☐ **Evaluation & Treatment**

PATIENT INFORMATION

Referred To: MRI T Spine Referred By: M. Chad Jackson Appt. _____

Reason for Referral: _____ Authorized By: _____

PATIENT/EMPLOYEE	EMPLOYER	CARRIER
NAME: David Wilson	NAME:	NAME:
DOI: 9-7-94	CONTACT:	CONTACT:
DOB: 1-19-57	PHONE:	CLAIM # (if assigned):
SS#: 260-94-5083	FAX:	PHONE:
PHONE: 770-684-3305	ADDRESS:	ADDRESS:
ADDRESS: 85 Ayers Rd Hartwell Ga. 30643		
	Description of Accident:	

DEAR PHYSICIAN: Please complete and fax this form within four (4) hours of your evaluation to (706) 290-8518.

PHYSICIAN INFORMATION

Diagnosis: _____

Recommendations/Treatment/Medications: _____

☐ **Re-check:** Date: _____ Time: _____

- ☐ No Follow-up Needed
- ☐ Physical Therapy-R.R.M.C.-P.T.
- ☐ X-ray / MRI / C.T. / NCV / EMG
- ☐ Surgery

All Surgical, Ancillary & Diagnostic Procedures not provided at Specialty Network Provider Site must be performed at Redmond Facility.

R.T.W. Disposition:

- ☐ Regular Work — As of: _____
- ☐ Temporary Modified — From: _____ To: _____
- ☐ Bed Rest — From: _____ To: _____
- ☐ MMI Achieved: _____

Physical Capabilities: _____

In an 8-12 hour work day, employee can:	Constantly (67-100%)	Frequently (33-66%)	Occasionally (0-33%)	Not at All
Stand/Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Drive	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Perform Work at Shoulder Level	☐	☐	☐	☐
Perform Repetitive Motions	☐	☐	☐	☐
Perform Overhead Work	☐	☐	☐	☐

Employee is able to lift no more than: ☐ 0-10 lbs. ☐ 10-25 lbs. ☐ 25+ lbs.

Comments: _____

Physician Signature: _____ Date: _____

Sender's Name: _____

WMR 00063

WHITE COPY: FAX to Injury Manager - Specialist Retains / YELLOW COPY: Employer/to Patient

770-684-hm
3305

770 324 2c
3357

REFERRAL REQUEST

PATIENT'S NAME: David Wilson

REFER TO: work hardening

DIAGNOSIS CODE (MUST HAVE): _____

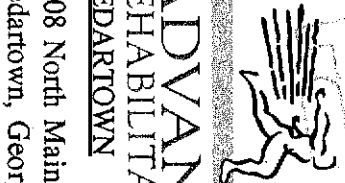
APPOINTMENT DATE & TIME: _____

PATIENT NOTIFIED: _____

RECORDS FAXED: _____

DMS 53016534 (R 8/00)

Patient Ref 'al



ADVANCE REHABILITATION

ROME
201 Turner McCall Blvd.
Rome, Georgia 30165
Phone: (706) 235-2727
Fax: (706) 235-2726

CHATTOOGA
11606 Highway 27
Summerville, Georgia 30747
Phone: (706) 857-6366
Fax: (706) 857-6372

CEDARTOWN
1108 North Main Street
Cedartown, Georgia 30125
Phone: (770) 749-0250
Fax: (770) 749-0086

WMR 00064

Physical Therapy Appointment: Date _____ Time _____

Patient Name: David Wilson

Diagnosis: Back Strain

Surgical Procedure: work hardening

☐ Consult: Evaluate & Treat

Precautions / Recommendations

Frequency _____ Duration _____

MODALITIES:
- ☐ Heat / Cold
- ☐ Electro-Stimulation
- ☐ Ultrasound
- ☐ Massage
- ☐ Other _____

TRAINING:
- ☐ Gait
- ☐ Fine Motor
- ☐ Transfers
- ☐ Balance

EXERCISE:
- ☐ Passive ROM
- ☐ Active ROM
- ☐ Resisted ROM
- ☐ Spine Stabilization
- ☐ Mckenzie Ex.
- ☐ Body Mechanics
- ☐ Home Ex. Program
- ☐ F.C.E.
- ☒ Work Hardening
- ☐ Traction
- ☐ Other

I certify that therapy services for the above named patient are required, medically necessary and authorized by me.

Next Appointment with Physician: 10-19-04

Physician Signature: _____ Date: 10-5-04

200 Piedmont Ave., SE
Suite 1208, West Tower
Atlanta, GA 30334-9010
Phone: 404-463-6308/877-656-7475
Fax: 404-656-9178

STATE OF GEORGIA
DEPARTMENT OF
ADMINISTRATIVE SERVICES
RISK MANAGEMENT

Fax

To: Redmond Occupational Health **From:** Rochelle Riley

Fax: 706-233-4006 **Pages:** (includes cover page) 3

Phone: **Date:** 10/06/04

Re: David Wilson **CLAIM#** WC05531736

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

This serves as a written request for current **visit note, work and treatment status upon availability. Give me a call if you have any additional questions. Thank You**

Employee: David Wilson

Employer: Department of Public Safety/770-324-3351

Adjuster: Deborah Cook/404-656-9483 92

DOI: 09/07/04, DOB: 01/19/57, SS# 260-94-5083, Claim# WC05531736

1-866-456-7475

Rochelle Riley
Medical Management
MCO Nurse

Phone: 404-463-6308
~~Fax: 404-656-9178~~

FAXED
10/6/04
BA

Redmond Occupational Health

A member of the Redmond Healthcare Network

Physical Therapy Referral & Evaluation Form

For questions or assistance, call Redmond Occupational Health at 290-8000.

PATIENT INFORMATION & AUTHORIZATION

Referred To: HeAlth South
Authorized By:
Appt. Date / Time:

Patient/Employee	Employer	Carrier
Name: DAVid Wilson	Name: GA STATe PATrol	Name: D.O.A.S.
DOI: 9-?-04	Contact: LiSA	Contact: ~~LiSA~~ RASHAW
DOB: 1-19-57	Phone: 770-387-3723	Claim# (if assigned): 0553173[illegible]
SSN: 260-94-5083	Fax:	Phone: 404-656-6245
Phone: 770-684-3305	Address: 1300 Joe Frank Harris Cartersville GA 30120	Address: PO BOX 38198 ATL GA 30334
Address: 85 Ayers Rd Aragon GA 30104	Description of Accident:	

The patient is referred to you for: Carrier MAKing Appt 404 656-9178 657-1188

Diagnosis:

Surgical Procedures and Precautions:

Evaluate & Treat as Indicated: ☐ Frequency: Debra 404 656 9677 Duration:

Modalities:
- ☐ Cryotherapy
- ☐ Elec. Stimulation
- ☐ Gait Training
- ☐ Hot Packs
- ☐ Iontophoresis
- ☐ Joint Moblization
- ☐ Jobst Compression
- ☐ Taping
- ☐ Massage
- ☐ ROM Exercises
- ☐ TENS
- ☐ Therapeutic Exercise
- ☐ Traction
- ☐ Ultrasound
- ☐ Whirlpool
- ☐ Biofeedback

Testing:
- ☐ Functional Capacity Evaluation
- ☐ Kin-Com Evaluation
- ☐ Musculoskeletal Assessments

Special Programs:
- ☐ Back School
- ☐ Hand Therapy
- ☐ Spinal Stabilization
- ☐ Work Hardening
- ☐ Job Site Analysis
- ☐ Diabetic Foot Care

Patient Visit Status: ☐ Phy Therapy Initial Eval ☐ 1 Week Eval ☐ 2 Week Eval ☐ 3 Week Eval ☐ 4 Week

Physical Capabilities:
In an 8-12 hour work day, employee can:

	Constantly (67-100%)	Frequently (33-66%)	Occasionally (0-33%)	Not at All
Stand/Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Drive	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Perform Overhead Work	☐	☐	☐	☐
Perform Repetitive Motions	☐	☐	☐	☐
Perform Work at Shoulder Level	☐	☐	☐	☐

Employee is able to lift no more than: ☐ 0-10 lbs. ☐ 10-25 lbs. ☐ 25+ lbs.

Physical Therapist Recommendations:
- ☐ ..... Progressing well, continue same plan and treatment
- ☐ ..... Slow progress, recommend physician re-evaluation to determine continuance of physical therapy
- ☐ ..... Subjective complaints inconsistent with findings
- ☐ ..... No progress, poor rehabilitation potential, discontinue therapy

Comments:

WMR 00066

Physical Therapist Signature: Date:

ATTENTION: FAX TO INJURY MANAGER AT 706-236-1902 IMMEDIATELY FOLLOWING VISIT. THANK YOU.

Sender's Name:

FAX COVER SHEET

MONROE COUNTY HOSPITAL
MEDICAL RECORDS DEPARTMENT
88 MARTIN LUTHER KING JR DR
FORSYTH, GA 31029

PHONE: 478-994-2521
FAX: 478-994-1965

SEND TO	
Company name: HCA	From: Deborah
Attention: April	Date: 9/8/04
Office location: Dr. Ed Meyers	Office location: Med. Records
Fax number: 706-233-4006	Phone number:

☐ Urgent ☐ Reply ASAP ☐ Please comment ☐ Please review ☐ For your information

Total pages, including cover: 9

COMMENTS

INSTRUCTIONS TO RECEIVER: Please verify the number of pages received. If any information is missing or received in error, please notify the sender immediately. The recipient of this confidential patient information is prohibited from disclosing the information to any other party. Once the information is no longer needed, please shred.

MONROE COUNTY HOSPITAL PO BOX 1068 FORSYTH GA 31029

amb.

EMERGENCY ROOM • OUTPATIENT REC

PATIENT NUMBER 123040	TYPE 3	PATIENT NAME WILSON DAVID		AGE 47	BIRTHDATE 1/19/1957	SEX M	M/S UU	DATE OF SERVICE 9/07/04	TIME 11:41	CLERK ID VAS			
ADDRESS - LINE 1 85 AYERS RD	ADDRESS - LINE 2		CITY ARAGON		STATE GA	ZIP CODE 30104	TELEPHONE 770-684-33						
PATIENT SSAN 260945083	NOTIFY IN CASE OF EMERGENCY - NAME		RELATIONSHIP		ADDRESS								
INSURANCE COMPANY			CONTRACT OR GROUP NUMBER			DATE		PLACE					
						TIME		EVENT					
GUARANTOR NAME WILSON DAVID	GUARANTOR ADDRESS 85 AYERS RD		CITY ARAGON		STATE GA	ZIP CODE 30104	GUAR. TELEPHONE 684-3305						
GUARANTOR EMPLOYER	GUARANTOR OCCUPATION		GUAR. EMPLOYER ADDRESS				GUAR. BUS. TELEPHONE						
PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME											

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	E.C.	MED. REC. # 119602	ADMITTING/2ND PHYSICIAN ROGERS J /				
							DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT, ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient
4. I/we hereby authorize the Administrator of Hospital or Controller of Hospital to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)
AMBULANCE

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	R.N. PHYSICIAN	TET. TOX.

NURSES NOTES:

LAB DATA (Including X-Rays, EKGs, etc.) NURSE'S SIGNATURE (RN OR LPN)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

INSTRUCTIONS TO PATIENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

WMR 00068

FOLLOW-UP WITH M.D.

PATIENT'S SIGNATURE ON DISCHARGE
BY SIGNING HERE I CERTIFY THAT I UNDERSTAND THE FOLLOW-UP INSTRUCTIONS RECEIVED BY ME IN WRITING, WHICH WERE EXPLAINED TO ME.

DATE - TIME OF DISC.

PHYSICIAN'S SIGNATURE M.D.

08

Monroe County Hospital
88 Martin Luther King, Jr. Drive Forsyth, GA 31029

EMERGENCY PHYSICIAN RECORD
Low Back Pain / Injury (5)

123040 RN- 119602 P/T-E/R
WILSON DAVID M 47
85 AYERS RD ARAGON , GA
ROGERS J
09/07/04 B/D 01/19/57

DATE: 9-7-4 TIME: 1145 ROOM: 107 EMS Arrival

HISTORIAN: patient spouse paramedics

HX / EXAM LIMITED BY:

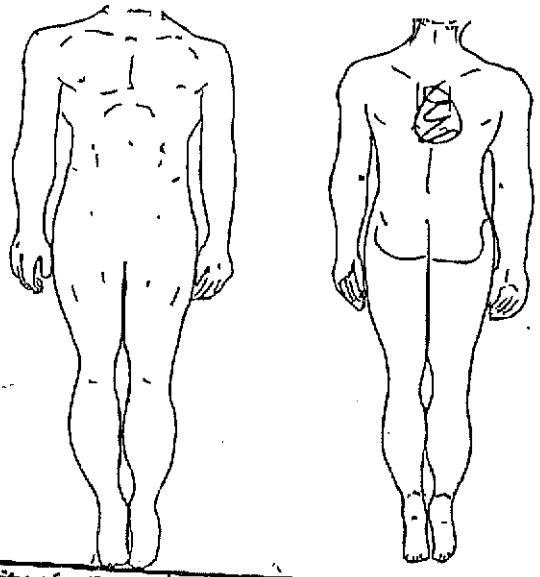
HPI chief complaint: back pain / injury chronic back pain

started (occurred): yesterday

recent injury? no yes possibly

Did not fall

Location & radiation of pain:



pain
paresthesias
paresis

quality and severity of pain:
burning / sharp / acute
dull / radiating
similar to prior back pain(s)
mild moderate severe

neurologic symptoms:
__bowel dysfunction
__bladder dysfunction
__radiation to leg
__sensory-motor loss

Modifying Factors:
exacerb. by:
supine / upright position
movement (activity/rest/flexion)
cough / deep breaths / marching

relieved by:
supine / upright position
rest
standing

ROS

GU
__trouble w/ urination
__frequent urination
__blood in urine

OTHER
__fever
__subjective / to ____ °F
__chills

Women only
__vaginal bleeding
normal period / abnormal
__vaginal discharge
__missed / abnormal period(s)

NEURO / PSYCH
__headache
__depression

EYES / ENT / PULMONARY / CV
__blurred vision
__sore throat
__cough
__trouble breathing
__chest pain

GI
__abdominal pain
__nausea
__vomiting
__diarrhea
__black / bloody stool

SKIN
__new rash

__ROS per nurse's note

PAST HX __negative

__prior back injury
__prior back pain
episode(s) chronic
__intervert. disc disease
__sciatica
__arthritis
__compression fracture(s)
__other problems GERD

__peptic ulcer disease
__aortic aneurysm
__kidney stone
__urinary tract infection
__prostatitis
__high blood pressure
__diabetes insulin / oral / diet
__heart disease

Surgeries / Procedures
__none / __noncontributory
__back surgery
laminectomy fusion discectomy

__chole-cystectomy
__appendectomy
__coronary bypass
__other

Medications __none __see nurses note
__ASA __NSAID __acetaminophen

Allergies NKDA
__see nurses note

SOCIAL HX __smoker
__tobacco (cigs / cigars / snuff)
__drugs
__alcohol (beer / liquor / wine / occasional)

FAMILY HX

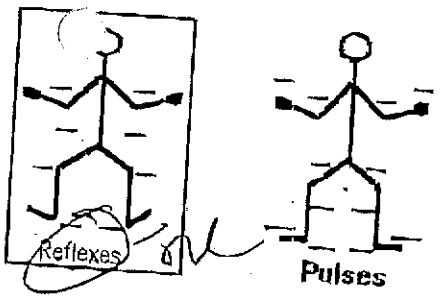
HR RR Temp Pediatric Immun. UTD

PHYSICAL EXAM

Alert Lethargic

Distress- NAD mild moderate severe

Other- c-collar (PTA / in ED) back-board IV



EENT
- nml ENT inspection
- pharynx nml
- scleral icterus / pale conjunctivae
- pharyngeal erythema

NECK
- nml inspection
- non-tender
- painless ROM
- thyromegaly
- lymphadenopathy
- limited ROM

RESPIRATORY
- no resp. distress
- breath sounds nml
- see diagram
- wheezing
- rales / rhonchi

CVS
- reg. rate & rhythm
- heart sounds nml
- tachycardia / bradycardia
- pulse deficit

ABDOMEN
- non-tender
- no organomegaly
- no pulsatile mass
- see diagram
- hepatomegaly / splenomegaly
- mass / prominent aortic pulsation
- femoral pulse deficit

BACK
- non-tender
- nml inspection
- painless ROM
- see diagram
- decreased ROM
- muscle spasm
- CVA tenderness
- vertebral point-tenderness

SKIN
- color nml, no rash
- warm, dry
- cyanosis / diaphoresis / pallor
- skin rash

EXTREMITIES
- non-tender, full ROM
- no pedal edema
- pedal edema
- calf tenderness

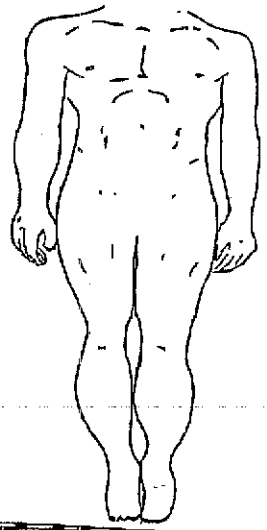
LABS, XRAYS and PROGRESS

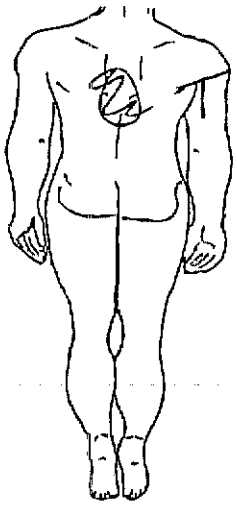
LABS: CBC WBC- HCT- Platelet-
UA- normal WBC- RBC- bacteria
BHCG (serum/urine preg POS/NEG

XRAYS Interp. by me Reviewed by me Discsd w/ radiologist

D-Spine LS-Spine
- nml / NAD
- no fracture
- nml alignment
- soft tissues nml
- reversal / straightening of cerv. lordosis
- DJD / spondylosis / spurring

Other See separate report



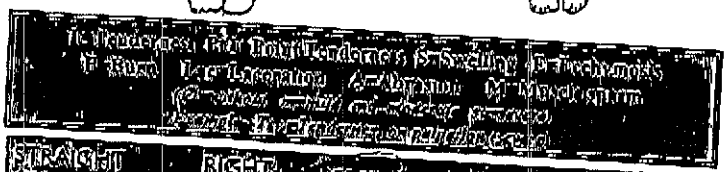


Time re-examined unchanged improved

Rx given

Discussed with Dr Time

will see patient in: office / ED / hospital



CLINICAL IMPRESSION:

Fall Alleged Assault

- Acute Myofascial Strain — dorsal lumbar sacral
- Low Back Pain - acute chronic
- Contusion - lumbar dorsal
- Spondylolysis Spondylosis Spondylolisthesis (at)
- Aortic Abdominal Aneurysm — ruptured enlarging
- Acute Sciatica L / R
- Acute Herniated Disc at
- Degenerative Disc Dz
- Urinary Tract Infection

NEURO / PSYCH
- oriented x3
- mood / affect nml
- no apparent motor or sensory deficit
- dorsiflexion of great toes normal bilaterally
- reflexes nml
- disorientation / CN deficit
- sensory / motor deficit
- antalgic gait
- decreased rectal tone
- clonus

DISPOSITION- home admitted transferred

CONDITION- unchanged improved stable

PHYSICIAN SIGNATURE-

Dictated Addendum Progress Sheet Template Complete

PHYSICIAN'S ORDERS

MONROE COUNTY HOSPITAL

EMERGENCY DEPARTMENT

NAME
ROOM NO (ADDRES) 123040 RM- 119602 P/T-E/R
HOSP. NO WILSON DAVID M 47
PHYSICIAN 85 AYERS RD ARAGON , GA
ROGERS J 09/07/04 B/D 01/19/57

Date & Time		Nurse Initials
	9.7.4 1130	
	NS iv @ KVO - pt fasts	
	UA - unable to obtain	
	X-. T spine. L spine - 7mg	
1140	MSO4 4mg IV - 1140 - [signature]	
	1335	
	MSO4 2mg iv - 1332 - [signature]	
	CT - T spine [signature] VS	
	1610	
	MSO4 2g iv - 1610 - [signature]	

EMERGENCY DEPARTMENT

Monroe County Hospital
88 Martin Luther King Jr. Drive
Forsyth, GA 31029

NURSING ASSESSMENT FORM

Date: 9-7-4 Time: 1120 hours

NAME: (Last, First): Wilson, David 47

COMPLAINT: Taser gun to back

ARRIVED BY:
- ☐ Walked
- ☐ Carried
- ☐ Wheelchair
- ☑ EMS

Accompanied by:
- ☐ Self
- ☐ Spouse
- ☐ Parent
- ☐ Other:

Condition:
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ CPR
- ☐ DOA

Pre-Hospital:
- ☐ C-collar
- ☐ Backboard
- ☑ IV/Fluids
- ☐ Splint
- ☑ Meds
- ☐ Other: NS RAC
- ☐ Monitor
- ☐ Intubation
- ☐ CPR
- ☐ Dressing
- ☐ O2

Pediatric:
Immun. Current: ☐ Yes ☐ No
Weight:
☐ Actions appropriate for age
☐ If No, Explain:
☐ Other:

ARRIVED FROM: ☐ Home ☐ Nursing Home ☐ Other:

VITAL SIGNS: ☐ Oral ☐ Axillary ☐ Rectal

Time	B/P	Temp	Pulse	Resp
1125	144/94	97.5	76	18
1500	133/84		72	20
1730				

PAIN SCALE: (0-10) 0 = None 10 = Severe

Time	Level	Location	Onset
1120	10	c mass	5 h

FACES PAIN SCALE:

0 1-2 3-4 5-6 7-8 9-10

PULSE Ox READING: ☐ N/A

Time:				
Result:				
On O2?:				
# Liters:				

TRIAGE LEVEL:
☐ Level III ☐ Level II ☐ Level I

FAMILY PHYSICIAN: out of town MD

HEALTH HISTORY:
- ☐ Negative
- ☐ Smoker
- ☐ ETOH
- ☐ Diabetes
- ☐ Cardiac
- ☐ COPD
- ☐ Seizures
- ☐ HTN
- ☐ Asthma
- ☐ Other: GERD

RESPIRATORY: ☐ N/A
- ☐ Clear
- ☐ Obstructed
- ☐ Diminished
- ☐ Rhonchi
- ☐ Rales
- ☐ Audible Wheezing
- ☐ Dyspneic
- ☐ Retractions
- ☐ Nasal Flaring
- ☐ Shallow
- ☐ Labored
- ☐ Assisted
- ☐ Tachypneic
- ☐ Cough
  - ☐ Productive
  - ☐ Non Prod.

CARDIAC: ☐ N/A
- ☐ Denies Complaint

CHEST PAIN:
- ☐ Yes ☐ No
- ☐ Constant ☐ Intermittent

PULSE:
- ☑ Regular
- ☐ Weak
- ☐ Bounding
- ☐ Irregular

SKIN:
- ☐ Warm ☐ Flushed ☐ Hot ☐ Cool
- ☐ Pink ☐ Cyanotic ☑ Dry ☐ Rash
- ☐ Pale ☐ Jaundiced ☐ Diaphoretic

TUGOR: ☐ Normal ☐ Decreased

NAIL BEDS: ☐ N/A
- ☑ Pink
- ☐ Dusky
- ☐ Pale
- ☐ Cyanotic

CAPILLARY REFILL: ☐ N/A
- ☐ > 2 sec ☐ < 2 sec

MENTAL STATUS:
- ☑ Awake
- ☑ Oriented x 3
- ☐ Confused
- ☐ Lethargic
- ☐ Unresponsive
- ☐ Non-Verbal

GYN: ☐ N/A
LMP:
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

G:___ P:___ AB:___
EDC:
FHT:

NEURO-Psycho/Social:
- ☑ Cooperative ☐ Flat
- ☐ Agitated ☐ Quiet
- ☐ Combative ☐ Homicidal
- ☐ Anxious ☐ Suicidal
- ☐ Crying ☐ Behavior Age Appropriate
- ☐ Depressed

CURRENT MEDS/DOSAGES:

fosamax

ALLERGIES (Drug, Food):

Latex: ☐ Yes ☐ No
☑ NK

Nausea: ☐ N/A ☐ Yes ☐ No
Vomiting: ☐ Yes ☐ No ☐ Blood Noted
Bowel Function:
☐ Normal
☐ Constipation
☐ Diarrhea
☐ Diarrhea > 24 hrs.
☐ Rectal Bleeding

Abdomen: ☐ N/A
☐ Soft
☐ Rigid
☐ Distended
☐ Tender
☐ Non-Tender
☐ Bowel Sounds
☐ Hyper
☐ Hypo
☐ Normal

Urinary: ☐ N/A
☐ Normal
☐ Burning
☐ Frequency
☐ Blood in Urine
☐ Incontinent
☐ Urgency
☐ Flank Pain (R) (L)

Pupillary Response: ☐ N/A
☐ Equal & Reactive
☐ Non-Reactive
☐ Brisk
☐ Sluggish
☐ Unequal
☐ Rt Pupil ____mm
☐ Lt Pupil ____mm

Visual Acuity:
RT_____
LT_____

1 2 3 4 5 6 7 8

MUSCULOSKELETAL: ☑ N/A
Location:_____
☐ Pain ☐ Dislocation
☐ Swelling ☐ Skin Broken
☐ Deformity

FUNCTIONAL ASSESSMENT: ☑ Full ROM
☐ Limited ROM Do you have problems performing normal activities of daily living?
☐ Yes ☐ No
Describe:_____

TRAUMA: ☐ N/A
Mechanism of Injury:
☐ MVA
☐ Other:_____
Area Affected:_____
LOC: ☐ Yes ☐ No

TYPE OF WOUND:
☐ Laceration ____cm
☐ Abrasion
☐ Avulsion
☐ Contusion
☐ Burn
☐ Site:_____
☐ Date of last Tetanus:

Circulatory status distal to injury site: ☐ Normal ☐ Abnormal
Neurological status distal to injury site: ☐ Normal ☐ Abnormal

NURSE'S NOTES: Alivan 2x IV en route by Ems. Dony GSP Tanny + had Tiger Eye to back → fell back + injured back & hx of back problems. IVFS + Lt Ac in Ems. 1540 - Pt medicated for pain per standing orders. Positioned for comfort. [illegible]

* SIGNATURE OF NURSE: [signature]

PAIN RE-ASSESSMENT

TIME	LEVEL	INITIALS
	2 /10	
	/10	
	/10	

DISPOSITION OF PATIENT: Driver: ☐ Yes ☐ No
☐ Discharged
☐ Admitted to Room _____
☐ Deceased @ _____
☐ Transferred to:_____ per _____
☐ Left w/o Tx (indicate time):_____ ☐ signed AMA sheet ☐ refused (explain:_____)
☐ AMA (indicate time):_____ ☐ signed AMA sheet ☐ refused (explain:_____)

CONDITION ON DISCHARGE:
☐ Improved
☐ Unchanged
☐ Stable
☐ Critical
☐ Deceased

DISCHARGED TO:
☐ Home
☐ Work
☐ Nursing Home
☐ Other:_____

LEFT VIA:
☐ Auto
☐ Ambulance
☐ Carried
☐ Wheelchair
☐ Ambulatory

Discharge instructions sheet given to patient: ☐ N/A ☐ Yes ☐ No Type:_____

Vital signs repeated if indicated: ☐ Hourly ☐ If above 170/100 ☐ Prior to Transfer

Time of discharge, admission, transfer 1555 hours

admission Report Called to: _____

* Signature of Discharge Nurse: [signature]

EMERGENCY DEPARTMENT AFTERCARE INSTRUCTIONS

Monroe County Hospital
Forsyth, Georgia 31029
478-994-2521

123040 RM- 119602 P/T-E/R
WILSON DAVID M 47
85 AYERS RD ARAGON , GA
ROGERS J
09/07/04 B/D 01/19/57

The treatment you have received in the Emergency Department was an emergency treatment only, and is not intended to be a substitute for or an effort to provide complete medical care. It is important that you contact your physician for follow-up care, and that you report to him/her any new or remaining problems. It is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. Meanwhile, follow the instructions as listed below.

- ☐ The interpretation of your x-rays as given to you by the physician in the Emergency Room is only a preliminary report. The x-ray specialist reviews these films. If there is a change in the diagnosis, you and/or your physician will be notified. If you cannot be reached by phone, please call the E. D. after 11:00 a.m. the next working day for results.
- ☒ The medication you have been given may cause drowsiness. DO NOT drive or operate machinery.
- ☐ Please read and follow attached instructions given to you about: ____
- ☐ Additional Instructions: Rest ... as soon as possible. ... return to Emergency Room if worse or new symptoms

by Dr. ____

- ☐ Call office to arrange an appointment to see your personal physician or Dr. Lamton at phone # 994 0M37 in ___ days for follow-up care or sooner if needed or return to the E. D. as needed.

I have received and understand the above instructions. I understand that I have had emergency treatment and that I may be released before all of my medical problems are known or treated. I will arrange follow-up care.

Patient/Responsible Party 9-7-4 Date Nurse

ORIGINAL: GOES WITH PATIENT COPY: STAYS WITH CHART

State of Georgia - Patient Care Report

Use Blue/Black Ink - Press Firm

Service Name: Monroe Co. EMS
Service #: 246
Response #: 04-2474
Incident Location: GPSTC
Today's Date: 9-07-04

PATIENT INFO

Patient Last Name: Wilson First: David MI:
Street Address: 85 Ayers Rd
City: Arcoga State: GA Zip Code: 30404
Phone: 770-684-3505 Age: 47 DOB: 7-29-57 Gender:
Social Security #: 260-[illegible]-5083 Hosp. Record #:

Transported To: MCH ER
Personal MD: Treating MD:
Responsible Party: Phone:
Street Address:
City: State: Zip Code:

CHIEF COMPLAINT: Back Pain
CURRENT MEDICATIONS: ☒ None Known
ALLERGIES (MEDS): ☒ None Known
PAST MEDICAL HX: ☐ None Known Heart Murmur (?)
NARRATIVE

(D) EMS resp to GPSTC GSP class for major back pain following being shot ē stun gun. Upon arrival pt sitting in chair C A&O x3. ABC's intact. Radial reg/strong. (A) skin cool/dry, hands cold. CMS's x4, secure. Guarding in severe resp distress. Pt denies LOC. Pain in back is 10 on scale. 1-10 if pt moves or is moved. Pt unable to stand. Breath sounds clear. (E) (B). Pupils PERRL. D5 NO. No P c/o/tenderness.

(R) Same

(T) Pt transported to MCHER for evaluation ē slightly following meds en route. Care transferred to staff.

TIME	EMT #	PULSE	RESP	B/P	Sa02	NEURO	ORDERS - TREATMENT - RESPONSE - Rx - EKG
1100		62	16	160/188	96	A	
				/			Pt Assessed
				/			VS Pulse Ox Oxygen NC @ 2 lpm
				/			Cardiac Monitor SR tachycardia
				/			IV 18 (R) AC Lab x 4 tubes
				/			On back @ 104 [illegible]
11:07				/			2mg Ativan slow IV push
				/			1000cc bag [illegible] running @ 300cc/hr
		70	20	160/182	98	A	Reassess
				/			
				/			
				/			
				/			

Patient Received By: [signature]
Date: 9-7-04
Drv/Medic: [signature] Certification and Number: 35857 I
Physician's Signature: [signature]
Date:
Medic 1: [signature] Certification and Number: [illegible]
Medic 2: Certification and Number:

12818434

WMR 00075

pt. is here now!

HCA PHYSICIAN SERVICES

[PRACTICE NAME]

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name: David R Wilson	Birth Date: 1-19-57	Social Security No. *(optional)*: 260-94-5093
Patient's Address: 85 Ayers Rd Aragon GA 30104	Requestor's Name/Phone Number (if patient is not the requestor): Redmond Family Care@West Rome / 706-233-40	
PHI Recipient Name: RFC@West Rome	Address/City/State/Zip: 2304 Shaw Ave / Rome / Ga / 30165	Phone Number: 706 233-400 Fax Number: 706 233-402
PHI Sender Name: Monroe Co. Hospital	Address/City/State/Zip: Forsyth / Ga / 31029	Phone Number: 478 994-25 Fax Number: (478 994-19

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)

Date: Event:

Purpose of Disclosure: labs + X-ray report

Is this request for psychotherapy notes?

☐ Yes, then this is the only item you may request on this authorization.

☒ No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
☐ All PHI in record		☐ Physician Orders		☐ Demographics	
☐ History and Physical		☑ Laboratory	9-7-04	☐ Rehabilitation Services	
☐ Consult Report		☑ Imaging/Radiology	9-7-04	☐ Special Test/Therapy	
☐ Operative Report		☐ Nursing Notes		☐ Itemized Bill/Claims	
☐ Progress Notes		☐ Medication Record		☐ Other:	

1. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign it.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative: David Wilson	Date: 9-8-04
Print Name of Patient's Representative: David Wilson	Relationship to Patient: Pt.